I. Introduction

A. Purpose

The mission of the Department of Managed Health Care (DMHC) is to help California consumers resolve problems with their Health Maintenance Organizations (HMO) and ensure a better, more solvent and stable managed health care system.

B. Activities

The Department's activities include:

1. Ensuring HMO accountability through enforcing prevention and quality of care laws;

2. Developing and launching public education and awareness efforts; and

3. Ensuring fiscal accountability for consumer premium dollars and co-payments throughout the HMO system.

II. Program Metrics

In connection with the Performance Improvement Initiative, the Department lists 9 metrics in three major programs:

A. Help Center

1. Resolution of every call – the Department provides statistics on the number of calls to the Call Center (around 150,000 per year for the first three years), but does not indicate how many were resolved.

2. Resolve complaints within 30 days – the Department just lists the number of consumer complaints from 2000/01 through the first six months of this fiscal year, and does not present performance results. The number of complaints ranged from 4,646 in 2000/01 to 6,689 in 2002/03.

3. Decision within 30 days of receipt of complete Independent Medical Review (IMR) package – the Department states that the IMR program began in January 2001, but does not provide either statistics or performance results.

B. Plan Medical Surveys

1. Conduct surveys at least once every three years – the Department did not provide statistics or performance results other than to note some of the surveys performed and to mention that it maintained a 100 percent on-time record for all required surveys and follow-up assignments.

2. Provide Plans with overviews of survey findings (preliminary reports) and notifications of deficiencies found by survey teams at least 90 days prior to the release of the public report – the Department lists the number of preliminary reports issued in each of the last three fiscal years, but does not provide any data on timeliness.

3. Final Reports of Routine Surveys are required to be in the Public File 180 days from completion of the survey on-site – the Department only provides the number of final reports issued for the past three fiscal years, but does not provide data on timeliness.

4. No later than 18 months following the release of the Final Report, the Department will conduct a follow-up review to determine and report on the status of the Plan's efforts to correct deficiencies uncorrected at the time of issuing the Final Report – the Department lists the number of follow-up reports issued, but does not provide data on the timeliness of the reports.

C. Financial Oversight

1. Conduct routine financial examinations at least once every 3 years – the Department provides statistics on the number of routine exams completed, but the only indication of performance is in a statement that it increased the frequency of financial examinations of health care service plans from every five years to every three years.

2. Conduct non-routine examinations on an as-needed basis – the Department lists the number of non-routine exams it has completed in the past three fiscal years, with the only performance reference being the statement that it increased the frequency of financial examinations of health care service plans from every five years to every three years.

III. Benchmarking

A. Help Center

Five benchmarks with the states of New York, Texas, and Florida comparing the number of health plans and enrollees, the hours of service, the number of calls received, information on consumer complaints (annual number of complaints, number of Independent Medical Review [IMR] applications and number of IMRs to review organizations) and staffing levels. Not all of the data are available from other states, but the available data show that California:

1. Has more Health Maintenance Organizations (HMO) and many more individuals enrolled (97 HMOs and 61.5M enrollees compared to 60 HMOs and 6.8M enrollees for the next largest, Texas).

2. Is the only state with 24/7 call center service.

3. Receives 18 times more calls than Florida, the only state with comparable information.

4. Has fewer complaints (6,689), but more applications for IMRs (2,788) than New York, the next largest state, at 12,732 complaints and 1,391 IMR applications.

5. Appears (although data from other states are incomplete) to have a larger staff, but probably not in comparison to the respective size of the populations served.

B. Plan Medical Surveys

There are no standards or benchmarks with other states.

C. Financial Oversight

Three benchmarks with the states of New York, Texas, and Florida.

1. California and New York had by far more completed financial oversight exams than Florida or Texas in the 3 ½ years compared. In 2000/01, California completed 27 exams compared to New York's 41, but California completed more exams than New York in all subsequent periods, with California completing 52 to New York's 40 in 2002/03.

2. While California conducted more total examinations than New York, it only examined about half the HMOs, while New York examined over 90 percent.

3. In comparing total assets ($18 billion) and revenues (over $55 billion), California dwarfs the other states, with the next largest, New York, at some $8 billion in assets and $15 billion in revenues.

IV. Department Website *(www.dmhc.ca.gov)*

A. Online services available to consumers

1. Access to Department grievance and IMR services

2. Access to the Department website library including:

   a. Copies of the Knox-Keene Health Care Service Plan Act.
   b. Current regulations.
   c. Proposed regulations.
   d. Listing of publications available through the Department.
   e. Answers to frequently asked questions.
   f. Director's Opinions.
   g. Department Advice.
   h. Department reports.

3. Access to Information About Health Plans page, which includes:

   a. A list of all licensed health plans.
   b. A link to the Financial Division page with financial reports about each health plan.
   c. Access to the Department's medical surveys of each Plan.
   d. A listing of Plan arbitration decisions.
   e. Access to the Department's complaint data reports.

4. Information about the Department's enforcement actions.

5. Access to information about the Department including:

   a. Mission statement.
   b. Overview of the Department.
   c. Organizational chart.
   d. Biographies of executive staff.
   e. Employment opportunities.

6. Link to the Office of Patient Advocate website and HMO report card.

7. Access to information about the Department's advisory boards.

8. A listing of helpful health-related websites.

9. A form to permit users to contact the Department with questions.

B. Services/information available to health plans and providers

1. Access to Department grievance and IMR services (as above)

    a. Information about how to assist a patient with the grievance process.
    b. Access to the Department website library (as above).
    c. Department advice.
    d. Regulations information.

2. Access to Information About Health Plans page (as above)

    a. News communications to health plans.
    b. Listing of official communications from the Department to health plans.
    c. Information and forms for submitting health plan financial information to DMHC electronically.